ADVANCED IMAGING

1639 N. Volusia Avenue, Orange City, FL 32763
Phone: 386-774-7226 Fax: 386-774-7227

Patient Registration Form

Patient Information

Patient's Name: Last_____First _____MI_____
Social Security #: _____-_____-_____ Male ____ Female ____ Date of Birth _____/_____/_____

Address:_____
City/State/Zip:_____
Phone #: Daytime (____) _____-_____ Evening (_____) _____-_____ Cell (____) _____-_____

E-mail address:_____
Emergency Contact: _____Phone #: (____) _____-_____
Relationship to patient:_____
Physician requesting exam: _____
Other physician to receive report:_____

Primary Insurance (provide your insurance card to the front desk at check- in)

Name of Policyholder: _____
Patient Relationship to Insured: _____
Policyholder date of birth: _____/_____/____Policyholder Social Security #: _____-_____-_____
Insurance Company Name: _____Phone#: (____) _____-_____
Insurance Company Address: _____
Policy #: _____Group#: _____

Secondary Insurance

Name of Policyholder: _____
Patient Relationship to Insured: _____
Policyholder date of birth: _____/_____/____Policyholder Social Security #: _____-_____-_____
Insurance Company Name: _____Phone#: (____) _____-_____
Insurance Company Address: _____
Policy #: _____Group#: _____

Hospice

Are you enrolled in hospice? □ Yes □ No If yes, is the reason for your appointment related to the condition or diagnosis for which you are enrolled in hospice? □ Yes □ No

Name of Hospice: _____

Hospice Phone Number: _____

Pregnancy Notice

There are unknown risks to an unborn fetus in any imaging study. If there is a chance that you may be pregnant, it is strongly recommended that you postpone any imaging studies until it can be confirmed that you are not pregnant.

I have read and understand the above statement. There is no chance that I am currently pregnant. Consequently, I am electing to have x-rays or other diagnostic imaging studies done at this time. I hereby release the ordering/attending physician, the imaging center and all of their physicians, agents and employees from all liability if it is determined that I am pregnant at this time.

_____ _____

Signature of Patient or Personal Representative Date

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

_____ _____

Signature of Patient or Personal Representative Date

****For the safety of our patients and staff the facility is under 24 hour surveillance.****

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Assignment of Benefits Form

Financial Responsibility
All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits
I hereby assign all medical benefits to which I am entitled. I hereby authorize and direct my insurance carriers, including Medicare, private insurance, auto insurance and any other health/medical plan, to issue payment directly to PROFESSIONAL RADIOLOGY ASSOCIATES (dba ADVANCED IMAGING PARTNERS) for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information
I hereby authorize PROFESSIONAL RADIOLOGY ASSOCIATES (dba ADVANCED IMAGING PARTNERS) to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing. I have requested medical services from PROFESSIONAL RADIOLOGY ASSOCIATES (dba ADVANCED IMAGING PARTNERS) on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and I agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____
Print Name of Patient/Responsible Party

_____ _____
Patient/Responsible Party Signature Date

_____ _____
Parent/Guardian Signature Relationship Date

_____ _____
Witness Date

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations.
You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by: _____
Printed Name - Patient or Representative

_____
Signature Date

Relationship to Patient
(if other than patient): _____

Witness: _____
Printed Name - Practice Representative

_____

ADVANCED IMAGING

Advanced Imaging
1639 N. Volusia Avenue
Orange City, FL 32763

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ **Date of Birth:** _____

Phone: H) _____ **Phone: W)** _____

Address: _____ **City/State/Zip:** _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:** _____

Facility Address: _____ **Facility Fax:** _____

City, ST, Zip: _____

Dates and Type of information to disclose:

☐ 2 years prior from last date seen
☐ Dates Other: _____
☐ Specific Information Requested:

_____

The purpose of disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care (e.g., VA Med Ctr)
☐ Referral
☐ Other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: ADVANCED IMAGING

Address: 1639 N. VOLUSIA AVE

City, State, Zip: ORANGE CITY FL, 32763

☐ **Please mail records.**

Fax: (386) 774-7227 **Phone:** (386) 774-7226

☐ **Please fax records.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:** _____. **If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____ _____

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

_____ _____

Printed name of Authorized Representative

Relationship / Capacity to patient

_____

Address and telephone number of authorized representative